coincidental, must result from a failure of aseptic techniques.

Any interference in a patient with a foetal death has some risk, and this risk must be weighed against that of conservative treatment. At a scientific meeting of the Royal College of Obstetricians and Gynaecologists Dr. Geoghegan, of Dublin, reported a maternal death resulting from amniotic embolus immediately after abdominal amniotomy in a patient with polyhydramnios; this must also be recognized as a rare but definite risk of the procedure. If induction of labour is thought necessary in a patient with foetal death intravenous oxytocin is probably the safest initial procedure. However, induction may fail in these circumstances, and it would still seem reasonable to use intra-amniotic hypertonic glucose or saline rather than prolong oxytocin therapy for more than two days.—We are, etc.,

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## Aversion Therapy

SIR,—Dr. Leon M. Shirlaw should not be exasperated (14 March, p. 701) when he sometimes reads of treatment with apomorphine referred to as aversion therapy. Notwithstanding its other properties, those of producing nausea and vomiting may be exploited for the purpose of inducing conditioned aversion. In his *Familiar Letters to the Lord Cliffe* (1634) J. Howell wrote ". . . . The German mothers, to make their sons fall into hatred of wine, do use when they are little to put some owls' eggs into a cup of Rhenish, and sometimes a little living eel, which twingling in the wine while the child is drinking so scares him, that many come to abhor and have an antipathy to wine all their lives after. . . ." I should regard that as an aversion technique even if owls' eggs were known to be sedative and twingling eels aphrodisiac.—I am, etc.,

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## Treatment of Subungual Haematoma

SIR,—Dr. G. H. Farrington (21 March, p. 742) rightly concludes that penetration of the nail by a red-hot wire-paper-clip is the most effective way of releasing a subungual haematoma. He does not, however, state those refinements of technique which render local anaesthesia unnecessary and retention of the nail more certain.

It is not necessary to express the haematoma if the hole in the nail is at least 2 mm. in diameter. The tension is released and the pain relieved as soon as the nail is penetrated. Any remaining subungual blood can be drawn out using the capillary action of the corner of a sterile gauze swab. The hole is made large enough by moving the red-hot paper-clip in a circle of the required diameter. The wire is frequently reheated in the spirit flame. No pressure is used, and the procedure is painless. It is important to make the hole large enough at the initial penetration, as it is difficult to enlarge the hole subsequently without the hot wire passing through and touching the very sensitive nailbed.

I have used this method for several years and the only complication I have encountered is a slight amount of fresh bleeding. This has caused no difficulty provided that the initial ostium was adequate to allow free drainage.—I am, etc.,

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## Treatment of Dumping Syndrome

SIR,—The article by Drs. M. B. Sullivan and B. R. Boshell (15 February, p. 414) on "Aetiological Factors and Therapeutic Approach to the Dumping Syndrome" was of special interest to us. Their findings that oral tolbutamide was effective in controlling dumping symptoms in a number of patients and that the intravenous tolbutamide test in these patients suggested a basic impairment of carbohydrate tolerance confirms our clinical and biochemical results in four patients with severe post-gastrectomy dumping treated with chlorpropamide for varying periods of time.[1] Clinical improvement occurred in all four patients after the institution of chlorpropamide therapy, but a relapse of symptoms ultimately necessitated a Billroth conversion in two of them. The 180-minute glucose-tolerance curve was "set" at a lower level when repeated while the patients were on chlorpropamide. We postulated that the therapeutic benefit of oral hypoglycaemic agents might be due to ensuring more uniform blood-sugar levels throughout the day, thus preventing the precipitate rise, peak blood levels, and rapid fall of blood-sugar concentrations. In addition, an increase in the fasting and 60-minute serum-insulin-like activity was demonstrated when the glucose-tolerance test was repeated while these patients were on chlorpropamide.

Sullivan and Boshell demonstrated that the response of the intravenous tolbutamide test on serum-insulin-like activity conformed to the type usually seen in patients with adult-onset-type diabetes mellitus. While our conclusions were similar in 16 patients tested, they were based on the finding that post-gastrectomy subjects tended to exhibit less marked hypoglycaemia after intravenous tolbutamide than normal controls.

Our fourth patient was of particular interest in that an overtly diabetic glucose-tolerance curve could be reduced to normal levels with chlorpropamide, and furthermore repeated glucose-tolerance tests performed since Billroth conversion now show completely normal results.[2]

We have since used oral chlorpropamide in a further six patients with severe post-gastrectomy dumping with satisfactory but not invariably complete remissions.[2] It would appear that oral hypoglycaemic agents may be of benefit in some 50% of patients with the post-gastrectomy dumping syndrome.—We are, etc.,

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## Cervical Spondylosis

SIR,—Dr. C. Shields (7 March, p. 633) asks why I prefer to give cervical traction with the neck in flexion? The short answer is easy, for, whereas traction is extremely effective when given with the patient supine and the neck at an angle of between 30 and 40 degrees with the horizontal, it is often ineffective and may even aggravate matters if carried out with the neck in the neutral or extended position. It is easy to see why: the cervical spondylitic who is in the throes of an acute episode usually obtains relief by flexing his neck, thereby enlarging the neural foramina. Conversely extension, especially if combined with side bending to the affected side, aggravates the symptoms; in fact many patients experience considerable difficulty in shaving under the chin during an acute attack.

Disk degeneration and narrowing in the cervical region not only causes neuro-central arthritis but also leads to over-riding of the associated zygapophysial joints, which in their turn become arthritic. A zygapophysial joint is a diarthrodial joint with synovial membrane and capsule, and many acute cervical episodes are due to trauma to an arthritic zygapophysial joint.

Whether the symptoms arise in an arthritic neuro-central joint or an arthritic zygapophysial joint, in either case the object of traction is to stretch gently the offending capsule or capsules; and this one cannot do with the neck in extension, in which position the pull would be applied to the oesophagus, trachea, and anterior longitudinal ligament.

Posture being what it is these days, the normal dorsal convexity of many adults, even the younger age groups, has already become somewhat exaggerated, while the majority of the middle-aged and more elderly, especially those with cervical spondylosis, have developed an uncorrectable upper dorsal kyphosis. Hence if traction is applied with the neck at an angle of 30 or so with the horizontal it will bring the cervical spine into line with the upper dorsal segments, and as the upper dorsal segments are very firmly braced by the rib cage I fail to see how traction can produce acute angulation in the D 1–2 and D 2–3 segments, as Dr. Shields suggests.—I am, etc.,

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## Emotional Hygiene in Pregnancy

SIR,—In his comprehensive and helpful article on "Minor Disorders of Pregnancy" (21 March, p. 749) Mr. Elliot E. Philipp reveals his refreshing sensitivity to the emotional difficulties of expectant mothers. Some of his observations require further emphasis in the light of current psychiatric theory and practice.

Mr. Philipp observes that the doctor can do more good by listening than by talking. Even more convincingly he describes his way of giving comfort by allowing the anxious patient to listen to the foetal heart; it is indeed a worthwhile experience on these occasions to watch for the smile coming to the patient's face. In his conclusion he suggests that many patients use the minor disorders of pregnancy "only as a bridge for making contact with their doctors." This is perfectly